

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL OF ANDERSON AND MADISC		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 N MADISON AVE ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00108449</p> <p>Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 8-30-12</p> <p>Facility Number: 005100</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>Community Hospital of Anderson and Madison County is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules.</p> <p>QA: cloughlin 10/30/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1